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Trauma-Informed Care For Youth In Foster Care

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Trauma-Informed Care For Youth In Foster Care

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University – University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Annually, in Minnesota, thousands of children enter the foster care system. The objective of this study was to use a trauma-informed lens to explore supports that are available to children, biological family members, and foster providers. Questions regarding the strengths and limitations of particular supports were also explored. This study used a qualitative design with five semi-structured interviews of mental health professionals. The main themes that were identified were: trauma-informed care, positives and challenges of formal and informal supports, involvement of biological and foster parents, differences in service to a child in foster care, and building a better system. The results imply that there are numerous therapeutic and community supports which all have their own strengths and limitations. The findings show that there needs to be more emphasis on the involvement of both the biological and foster families in supports provided to foster children. Ultimately, there is considerable room to make improvements within the system that supports foster care children and their families.

Keywords: Trauma-Informed, Foster Care, Foster Children, Attachment, Therapy

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Trauma-Informed Care for Youth in Foster Care

Children entering into the foster care system after having been removed from their families due to abuse, neglect or abandonment face some of the most difficult challenges moving ahead. The Adoption and Foster Care Analysis and Reporting System (AFCARS) analyzes the number of children in foster care, and according to the Department of Health and Human Services (2016) report, 427,910 children were in the foster care system in the United States during 2015. When children enter foster care, it has been alleged and determined that children are in need of protection or services meaning that child has experienced physical abuse, sexual abuse, and/or neglect (Department of Human Services, 2016). Children enter the foster care system either by being placed on a 72-hour law enforcement hold, which is then heard in court and determined if continued placement is required, or by immediate court action requesting placement of the child be ordered. Reports of child abuse are analyzed using the Minnesota Child Maltreatment Screening Guidelines. When children are removed from their homes and placed into foster care, this often causes disruption in their lives, which can have negative implications for a child's mental health.

Any child may develop an attachment disorder, but foster children have additional risk factors that could make them far more susceptible to forming irregular attachments compared to their counterparts. Children are being placed into foster care during a point in their lives when their brain is developmentally sensitive. There is a this sense a threat to their development from abuse and/or neglect. "Most of these children have been the victims of repeated abuse and prolonged neglect and have not experienced a nurturing, stable environment during the early years of life" (Committee on Early Childhood, Adoption and Dependent Care, 2000). "Children

in foster care have disproportionately high rates of physical, developmental, and mental health problems” (Committee on Early Childhood, Adoption and Dependent Care, 2000, p.1145).

Children in foster care can develop attachment or adjustment disorders due to a lack of nurturing relationships in early development. Jones & Morris (2012) define adjustment as “the lack of behavioral and emotional problems and the presence of adaptive functioning (p.130). Unfortunately children with adjustment or attachment disorders have an increase in emotional or behavioral problems. “Developmentally, children are often affected by their early experience, leading to problems with physiological, emotional and behavioral regulation, relationships and cognitive difficulties” (Golding, 2007, p. 39). With the climbing rate of children entering the foster care system Minnesota, a 33% increase from 2013-2015 (DeGarmo, 2017), professionals engaging with this population need to be aware of the concerning increase of children also being diagnosed with attachment disorders. Determining the exact number of children diagnosed with an attachment disorder is nearly impossible due to confidentiality and lack of research, but the impact it has on the child and the foster parent is a true concern.

Unfortunately children in foster care have high rates of instability. “Instability of a rearing situation can be operationalized by observing the number of experienced placements by the child within a specified time interval between and within providers of child welfare” (Strijker, Knorth, & Knot-Dickscheit, 2008, p. 109). When children move placements it can hinder their attachments, given that they were already removed from their family. Strijker, Knorth, & Knot-Dickscheit, (2008) note that when foster children “move from one place to another, earlier social relationships will be lost. Moving to another place involves adapting to a different social and physical environment” (p. 110). Children can develop obstructed attachment

when removed from their family, which may manifest into increased behaviors, causing children to be removed from their current foster home.

“Heflinger, Simpkins, and Combs-Orne (2000) examined 254 children (ages 4–18 years), who were wards of the state of Tennessee during January of 1996. Caretakers of the children completed the Child Behavior Checklist (CBCL), which assesses clinical elevations of children” (Jones & Morris, 2012, p.130). Jones and Morris (2012) found that 34% of sampled foster children showed clinically increased aggression, delinquency, destructive, and withdrawn behaviors (p. 130). The overall findings of this sample show that children in foster care have an increased risk for behavior problems. Jones and Morris (2012) also found that foster children have elevated risks of academic difficulties. Foster children are often removed from their families with limited warning or preparation. These children are sometimes placed in areas outside of their school district, removed from friends, and other community supports. These changes affect foster children and pose an increased risk of behavioral, academic, and delinquency issues, which can impact the child’s continued foster care placement.

This issue affects both the children and the foster parent. As children move placements, their development and attachment can be hindered. This can lead to additional moves as difficult behaviors may increase past the foster provider’s knowledge, expectations, and ability. When children are placed into a foster home, foster parents are taking responsibility to care for those children. When children are unable to remain in a home foster parents may “have a sense of failure and will then decide to stop fostering altogether (Strijker, Knorth, & Knot-Dickscheit, 2008, p. 111). This could mean a decrease in foster homes and an increase in children’s behaviors. Using the lens of trauma-informed care, this qualitative research explored the supports

that are available for both children and their foster providers to increase their success and longevity in their current foster home, to strengthen attachment and to increase children's emotional and behavioral regulation. Specifically, I asked a sample of five professionals about both formal and informal strategies they use or see as important from a trauma-informed perspective, with the goal of supporting young people during this important transitional time.

Literature Review

Child Protection System

The child protection system has been expanding and defining its duties since the 1800's. The child protection system can be understood from the perspective of three distinct eras. The first era is from the colonial times to 1875. This first era is considered to be non-organized child protection. During this time, children were considered to not have a formal protection system. The second era is from 1875 to 1962 and is considered organized child protection with no governmental supports. The third era is the modern era from 1962 to the present. The modern era offers, a government-sponsored child protection system (Myers, 2011). The modern era (1962 – present) can be understood as a time when the people began to discover the issues around abuse and neglect and the need for governments to enforce how child protection issues are addressed.

In the current era, physicians have served as a driving force behind the child protection issue that has spread across the nation. During their medical school training, physicians were not educated about child abuse, detection, or reporting procedures. Many cases of suspected child abuse were misdiagnosed as accidental death. Hospitals across the nation were asked to participate in a survey to review cases of physical abuse. In the “Over the one year study, 71 hospitals replied, 302 cases were reported to have occurred, 33 of the children died and 85 suffered permanent brain injury” (Kempe, 1962, p. 1). Only one third of those abuse cases were diagnosed properly and were followed by court action. The lack of education and literature made for suspected child abuse to go unnoticed.

During this same time period, the federal government was beginning to support child protective services with Congress amending Roosevelt's New Deal in 1962 to include “Child Protective Services as part of all public child welfare. All states pledged by July 1st 1975 child

welfare would be provided state wide services” (Myers, 2011, p. 455). Additionally in 1962, the federal Children’s Bureau started having meetings to discuss reporting laws. By 1963, the first four reporting laws were enacted, one being “doctors would now be required to report suspicions of abuse to the police of child welfare services (Myers, 2011).

The federal government started taking a more prominent interest in child protection during the 1970’s, and in particular in 1973, when it was discovered there was a lack of assigned duties for federal employees. “U.S. Senator Walter Mondale stated, nowhere in the deferral government could we find one official assigned full time to the prevention, identification, and treatment of child abuse and neglect” (Myers, 2011). Soon after in 1974, the Child Abuse Prevention and Treatment Act of 1974 (CAPTA) was adopted. This act approved federal funds to assist states with their responsibilities in addressing physical abuse, neglect, and sexual abuse (Myers, 2011). The National Center on Child Abuse and Neglect was then accountable to administer the CAPTA funds to those states and monitor the research each was doing on maltreatment (Myers, 2011).

Foster Care

When children are removed from their home due to abuse or neglect they may need to move into a foster care setting. There are multiple types of foster care settings based on the needs specific to that child. When placement types are being sought out for children, a least restrictive method is followed. Children can then be placed in short-term or long-term traditional foster care. This definition is fluid and is based on the intentions of the foster parents and the expected amount of time the child will be in care. Children with more physical, mental, or educational needs may require a therapeutic or treatment foster home. These homes provide “clinical intervention, which includes placement in specifically trained foster parent homes, for youth in

foster care” (Boyd, 2013, p.1). When children’s mental health needs exceed the care of a therapeutic foster home, a residential treatment facility provides the highest level of care. Boyd (2013) describes residential treatment placements as typically following a behavior modification or relationally based program model, with an institutional based setting.

Foster Children

Children who enter into the foster care system can be placed in multiple different placement settings. Children can be placed in relative or non-relative foster care, group homes, residential treatment facilities, hospitalizations, or any combination of the above. According to DeGarmo (2017) the average child is placed in foster care for 13 months, with the average age being eight. Golding (2007) stated, “children [in placement] often appear younger than their chronological age as they become stuck in age inappropriate response patterns which affect and distort their development” (p.39). “Developmentally, the children are often affected by their early experience, leading to problems with physiological, emotional and behavioral regulation, relationship and cognitive difficulties” (Golding, 2007, p. 39). Morrison & Mishna (2006) found that between 35% and 85% of children in foster care have significant mental health problems that require therapeutic interventions (p. 471).

Children have different experiences being placed in short-term versus long-term foster care. Short-term foster care is referred to when the goal of the social services plan remains reunification with the primary care giver. Long-term foster care is when reunification is no longer an option for the child and foster care or adoption becomes the plan for that child (Perkins, 2014). Children can experience shorter or longer placements depending on the severity of issues that the parent is trying to overcome. Parents who struggle with chemical and mental health may need more time to work through their services before being able to provide a safe

home. Children, who have been abused by one parent, may be able to return home quicker, if that parent is no longer in the home.

“Children who experience long-term separation from parents may be pre-occupied with their birth families, and this may have an impact on their relationships with new parental figures” (Biehal, 2014, p. 966). Biehal (2014) states children in long-term foster families may come to consider a foster placement as home while also feeling a sense of connection to their birth families. For them, ‘home’ may not be a stable origin in a single place, “but rather a set of spatial, social, psychological and temporal domains in which they feel a sense of belonging” (p. 968).

Trauma and Attachment

The first formulation and articulation of an attachment theory began with John Bowlby and Mary Ainsworth who independently explored the importance of a secure connection between and child and mother (Bretherton, 1992). “Attachment refers to a behavioral propensity to seek contact and proximity to an attachment figure when feeling insecure, due to perceived danger, illness, exhaustion, or other natural cues to danger (Schuengel, Oosterman, & Strekenburg, 2009, p. 2). Ideally when children are born their parents provide a loving and caring home which helps build attachment and security between that child and parent. According to Cassidy, Jones, and Shaver (2013) “in the first year of life, mentally healthy individuals develop a “secure base script” that provides a causal-temporal prototype of the ways in which attachment-related events typically unfold (e.g., “When I am hurt, I go to my mother and receive comfort”)” (p. 1416). “Theoretically, secure children's and adults' scripts should allow them to create attachment-related ‘stories’ in which one person successfully uses another as a secure base from which to explore and as a safe haven in times of need or distress. Insecure individuals should exhibit gaps

in, or distortion or even absence of, such a script (Cassidy et al., 2013, p. 1416). When children have discord with their parental figure it can impact their positive attachment.

During the 1940's children were being institutionalized and separated from their parents. Bowlby used his education and employment to study children in these institutions, but having staff comment daily on their moods and behaviors (Bretherton, 1992). "Bowlby's major conclusion, grounded in the available empirical evidence, was that to grow up mentally healthy, "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (Bretherton, 1992, p. 765). Children observe the world around them and make predictions from past life experiences. Children are able to use "rational constructivism, which is based on the idea that infants use probabilistic reasoning when integrating existing knowledge with new data to test hypotheses about the world (Cassidy, Jones, & Shaver, 2013, p. 1417). The same idea of shifted attachment can be said for children who experience disruptions with attachment and are forced to live somewhere else.

Children who are moved into the foster care system have experienced some form of traumatic event and it can impact them differently depending on the child. "A history of persistent maltreatment is the most common background for out-of-home placement of children and the failure of biological parents to care for their children is often correlated with mental health problems (Oswald, Heil, & Goldbeck, 2009, p. 462). Children who are removed from the home can show decreases in neurobiology, health functions, empathy and compassion, and school readiness compared to children who are not removed from their caregivers (Cassidy et al., 2013). "Attachment disruptions appear to have consequences for functioning and development

that are not confined to the domain of close personal relationships, including behavioral maladjustment and cognitive development” (Schuengel et al., 2009, p. 2).

Children face these difficulties by being removed from their families, but also as they may drift between foster homes. “The term foster care drift is used when a child moves from one placement to the other without the prospect of a permanent residence” (Strijker, Knorth, & Knot-Dickscheit, 2008, p. 108). Children process traumatic events differently because all children are different in some ways; there are therefore different methods of therapeutic supports for children with attachment disorders.

“Attachment is the reciprocal, enduring, emotional, and physical affiliation between child and a caregiver” (Carnes-Holt, 2012, p. 420). Children with strong attachment understand that the adults in their world are there to support them and keep them safe. Attachment can be hindered for children who have not received support or safety from their caregiver(s). Attachment disorders affect many children in the foster care system. According to Revans (2008) there are two different types of attachment: inhibited and disinhibited. Inhibited attachment results in a sense of security in one’s relationships. Disinhibited attachment can lead to the child forming inappropriate relationships (Revans, 2008).

Morrison and Mishna (2006) “found that foster infants and toddlers have poor attachment signaling and regulatory problems that contribute to difficulties in establishing secure relationships” (p. 471). The concern for attachment disorders increases when children are removed from their families and placed into foster care. “Elements of the theory were critical to making a strong case against casually moving children around within the foster care system without recognizing ongoing connection to birth or foster families” (Rittner, Affronti, Crofford, Coombes, & Schwam-Harri, 2011, p. 365). The likelihood of attachment disorders occurring can

increase more drastically for children who drift from placement to placement in the foster care system.

Therapeutic Models

Formal.

Research supports the need for therapeutic interventions for children in foster care who are displaying attachment difficulties, but similar to any intervention, it must be completed by a trained professional who is well versed in child attachment disorders (Revans, 2008). Scholars state it is important to emphasize the relationship between the child and the foster parent engaging in therapy. Attachment-based therapies encourage this positive engagement (Barth, Crea, John, Thoburn, & Quinton, 2005; Carnes-Holt, 2012; Golding, 2007). Golding (2007) explains a particular model of therapeutic intervention that helps identify the parent's strengths and weaknesses to improve parenting skills that assist the child in developing healthy attachment and appropriate behaviors. These therapies work to repair the child by labeling and working through the psychological defenses to encourage the rebuilding of trust (Barth et al., 2005).

Child-parent relationship theory (CPRT) is an effective model for foster parents and the children they care for (Carnes-Holt, 2012). Carnes-Holt (2012) reports that while "attachment disruptions indicate the presence of a relationship-based problem, CPRT's focus on the parent-child relationship makes it an appropriate therapeutic treatment modality for helping adoptive families respond to the challenge of establishing and maintaining a secure relationship (p.419). Along with CPRT is Parent Child Interaction Therapy (PCIT), which has been shown to help enhance foster parents' outlooks on children's behaviors. PCIT is a therapeutic approach designed for children ages 2-7 years old, which consists of weekly sessions coaching the parents to develop skills in managing foster children's behaviors. PCIT uses psychoeducation, coaching,

modeling, and role-playing to assist the foster parent in emerging specific skills (Mersky, Topitzes, Janczewski, & McNeil, 2015). PCIT and CPRT have been proven to reduce parent stress, which increases parenting skills (Carnes-Holt, 2012; Mersky, Topitzes, Janczewski, & McNeil, 2015).

A debated therapeutic method is a holding technique. This approach is thought by some to offer a rapid repair of attachment between a child and their primary care giver. The parent proceeds to hold the child tightly as the child moves through stages: bargaining, anger, rage, acceptance, and bonding (Barth et al., 2005, p. 261). Barth et al. (2005) cautions the misuse of attachment holding. The United States has issued specific guidelines for this technique due to the balance between good and the risk of harm.

Informal.

Children and their foster families benefit from formal supports to rebuild attachment, but they also utilize informal supports to assist in relationship building. Families have reported that using respite or taking a break was highly valued while providing foster care. Providers stated that having a supportive extended family help encourage them and provided support when working with behavioral children. Having other peers or support groups that are past or current foster/adoptive parent's assisted current providers with struggles in the home (Bonin, Beecham, Dance & Farmer, 2013).

The North American Council on Adoptable Children (NACAC) (2002) suggests that placement stability is a heavy factor in the success of foster children. Placement instability decreases the ability to build sufficient relationships. Foster providers who carry certain emotional characteristics may be able to enhance the stability support for children in foster care.

Characteristics include: humor, flexible expectations, and a tolerance of negative feelings or rejections (North American Council of Adoptable Children, 2002).

Increased training and ongoing training of foster parents provides as a large support for family systems. Foster parents have required trainings they need to complete during a licensing process, but the push for continued non-mandatory trainings that are specific to the child in care, weights heavily on the benefits for the parent child relationship (North American Council of Adoptable Children, 2002).

Conceptual Framework

The framework that was utilized for this research design was trauma-informed care, as trauma-informed care is more specific to this research project compared to attachment theory. Trauma-informed care is a relatively new concept, which has been developing for the last 30 years. Trauma-informed care “looks at how the entire system is organized and services are relived through a ‘trauma lens’” (Wilson, Pence, & Conradi, 2013, p. 2).

Wilson, Pence & Conradi (2013) explain trauma-informed care as a response that is specific to the individual. Trauma-informed care began in the late 1990’s as professionals working with individuals with significant trauma, benefited from a cohesive approach to service delivery. As individuals were connected to multiple services, a missing link of communication between those services was missing. In turn, individuals faced higher rates of re-traumatization due to a lack of communication. With the increase in multidisciplinary teams, a larger focus was taken to examine a trauma-informed approach to providing care. The growth of children in the welfare system and individuals with combat-related post-traumatic stress disorder provided an advance from individualistic care to trauma-informed care (Wilson, Pence, & Conradi, 2013).

Five Core Values

Physical and Psychological Safety.

Providing trauma-informed care can differ between agencies and disciplines. Wilson, Pence, & Conradi (2013) “suggest that trauma-informed care is built on five core values: (1) safety, (2) trustworthiness, (3) choice, (4) collaboration, and (5) empowerment” (p. 7). The five core values highlighted are emerging themes that are present in research surrounding trauma-informed care. The individual needs to feel a sense of safety, which is described as both physical safety and physiological safety. Wilson, Pence, & Conradi, (2013) provide an example of

children who are removed from their home because of safety concerns. That child may be physically safe in their foster home, but being removed does not guarantee psychological safety necessarily. When an individual is able to feel both physically and psychologically safe a sense of trustworthiness is more prominent and able to develop.

Empowering Individuals.

Partnering with clients increases the choice and collaboration that an individual has over their own services. The individual ‘being in the driver’s seat’ of their life creates empowerment for individuals to seek services and provide feedback on services that they feel will benefit them in working through their trauma. Assisting individuals in being in control of their services and supports can assist the mental health professional in understanding how trauma has impacted the individual and family as a whole. Mental health professionals are also able to begin to understand the “impact of trauma and how it influences their life and short- and long-term recovery” (p. 11).

Individual Internal and External Resiliency.

Resiliency of the individual, family, and professionals working within a trauma-informed system is a critical component to providing a trauma-informed lens. Wilson, Pence, & Conradi (2013) believe that resiliency is both an internal and external resource that individuals carry with them. Internal resiliency may be described as temperament or stress management, as external resiliency may include social relationships or activity participation. When providers are practicing trauma-informed care, they seek to assist the client with building upon their internal and external resilience. For assistance in understanding the unique supports available to an individual, assessment tools can be used. Acquiring information, providing education, and

gauging secondary trauma surrounding family members can enhance family protective abilities, which can increase an individual's well being.

Partnering with Agencies.

Individuals who are providing trauma-informed care need to emphasize parallel practice with other supporting agencies the client is accessing. This is extremely important to avoid adding additional traumas or triggering an individual. Wilson, Pence, & Conradi (2013) caution “professionals pursuing their own mission and goals independently can work at cross-purposes and trigger traumatic reactions, and can cause more harm” (p. 18). Trauma-informed care works best when all facets are working under the same trauma-informed lens and can “infuse and sustain trauma awareness, knowledge, and skills into their organization cultures, practices, and policies” (p. 18).

Methodology

Research Design

The purpose of this study was to explore trauma-informed formal and informal supports for foster parents caring for foster children with diagnosed attachment disorders. Literature suggested that there is an increased number of children with diagnosed attachment disorders in foster care for multiple reasons. Literature also suggests that there is a need for formal as well as informal supports for those foster parents and children. This study utilized a qualitative research design to improve understanding of the trauma-informed supports available for parents and foster parents caring for children with attachment disorders.

Population and Sample

The study sample was comprised of five mental health professionals who have provided therapeutic services to children in foster care. Those same mental health professionals have provided therapeutic services to children diagnosed with an attachment disorder. Participants were selected based on a purposive sampling.

Purposive sampling is a “nonprobability sampling procedure in which research participants with particular characteristics are purposely selected for inclusion in a research sample; also known as judgmental or theoretical sampling” (Grinnell, Williams, & Unrau, 2016, p. 541). The participants were selected with the following criteria: being a mental health professional, currently or historically providing therapeutic care to foster children, and the same foster child currently or historically has had a diagnosable attachment disorder. The researcher’s committee members and professional colleagues of the researcher assisted by proposing potential interviewees for this study.

Protection of Human Subjects

The University of St. Thomas Institutional Review Board (IRB) reviewed the study under exempt status before the process of data collection began. An informed consent form was created, which reviewed the purpose of the study, voluntary nature of the study, and the confidentiality rights of the interviewee (Appendix A). The informed consent form was created from a template approved by the University of St. Thomas IRB. Interviewees received the informed consent and interview questions in advance, and then were allowed to ask questions before signing the informed consent form. Interviews took place once the research's committee and St. Thomas IRB approved the study.

The researcher sought out interviewees by telephone based on suggestions from committee member's and professional colleagues. Telephone calls described the research project and role of the interviewee. Interested participants received an email detailing the research project and then were able to inquire about participation. Participants were not asked via phone to agree to be an interviewee with the goal of reducing any potential coercion.

Data Collection

A qualitative research design was used to gather data from interviewee's through semi-structured interviews. Interviews were guided by multiple interview questions, which were authorized by the researcher's committee members and St. Thomas IRB (Appendix B). The questions were created using the conceptual framework outlined by Wilson, Pence, & Conradi (2013) which provided emerging themes about trauma-informed care.

The researcher contacted potential interviewees via telephone to explain the purpose of the study. The researcher did not ask potential interviewees to agree to participate via phone; instead the researcher invited potential interviewees to inquire for more information if interested in becoming a research participant. Once individuals inquired, a detailed email outlined the role

of the interviewee and provided the consent form and interview questions for review. Once five participants were identified, interviews took place in a neutral location agreed upon by both the researcher and interviewee.

Interview questions were structured based on the literature review and conceptual framework. The interview questions began with the boarder topic of attachment and filtered down to specifics about formal and informal supports. Each interview took between 30 minutes and 90 minutes. Interviews took place with the use of an audio recorder. Within 24 hours of an audio-recorded interview, the interview was uploaded to the researcher's private computer. Immediately after, the interview was permanently deleted from the audio recorder.

The researcher's computer is password protected and the specific file folder is also password protected to decrease any privacy risk to the interviewee. Interviews will be stored until May 31 2018, on that date all audio-recorded interviews will be permanently deleted. Interview transcriptions were saved in a different password protected file folder. Signed consent forms were also saved in a different password protected file folder to increase confidentiality. The interviewer completed the transcriptions without the assistance of transcription software.

Data Analysis

The data were analyzed using both inductive and deductive approaches. After the interviews were transcribed, the researcher used inductive reasoning or open coding to listen for similar concepts or themes. Inductive reasoning is "building on specific observations of events, things, or processes to make inferences or more general statements" (Grinnell, Williams, & Unrau, 2016, p. 533). The open codes identified by the researcher were color-coded blue. The researcher then used deductive reasoning to listen for specific categories based on the literature review. Specific categories were "trauma-informed care, formal support, and informal support".

Deductive reasoning is “forming a theory, making a deduction from the theory, and testing this deduction, or hypothesis against reality” (Grinnell, Williams, & Unrau, 2016, p. 528). The deductive theories identified by the researcher were color-coded orange. The researcher then repeated the inductive reasoning or open coding to ensure concepts were recognized. The second inductive reasoned code was color-coded green. The transcribed interviews were color-coded to highlight reoccurring codes and themes, both in the inductive and deductive approaches.

Strengths and Limitations

The strengths of completing a qualitative research design is that by using semi-structured interviews, the researcher explored questions and answers more in depth than a survey method could. The use of interviewing allowed the researcher to follow the interviewee and adapt the framework to explore other concepts. Specific strengths of this research design were that the interviews were completed by mental health professionals about the supports for foster children and their foster parents. By interviewing the mental health professional, the study reduced the risk of harm to the interviewee.

A limitation of using this qualitative research design is that the research collected depended on the expertise of the interviewee. Qualitative research also creates a larger amount of data which then needed to be analyzed multiple times. This research only interviewed five interviewees. Due to the limited number of interviewees, data cannot necessarily generalize to a larger population.

Results

Participants shared the importance of a trauma-informed lens when working specifically with children who have spent time in the foster care system. Each participant described formal and informal supports similarly and pointed out the positives and challenges to supports available for children and their families. Participants spoke about the participation of biological parents and foster parents including an overwhelming need for increased involvement of each. Participants shared different practices when delivering services to children who have experienced foster care and children who have not. Lastly, participants shared ideas about how to improve our current system.

Trauma-Informed Care

Participants gave well-rounded descriptions of trauma-informed care and their experiences implementing a trauma-informed lens when working with children who have been in the foster care system. One participant stated:

“Trauma-informed care is having an understanding of how trauma impacts the brain, impacts behaviors, impacts relationships, being able to work with a child based on those needs, and that they are not necessarily coming up in the world from a neuro-typical way.”

Another participant described trauma-informed care as *“understanding that somebody’s life experiences, if it’s negative, is going to affect their behaviors sitting here today.”* Participants spoke to the importance of educating the child and their support system on what it looks like to be trauma-informed. A participant shared that, *“we need to realize and understand that a person’s responses are normal from their experiences, and that we need to reaffirm that they are not weak, crazy, or alone.”* Informing individuals is based especially on education, trainings, and

hands-on skills work. All five participants expressed the same importance of education with the biological family or foster family. One participant stated, *“I work with parents, caregivers, and children to help them understand how their children having experienced trauma makes them different from children that have not.”* One participant shared that there are tools they use with the family to help them visualize the impacts of trauma on the child. That participant stated, *“I do a lot of things with the ACE’s (adverse childhood experiences) to give them a lens, because not everybody knows that they are displaying all of these behaviors based on trauma.”*

Overall, all five participants expressed an importance to having a trauma-informed lens, as each described it differently, but with similar basic concepts. All participants shared that they use this lens when working with children in both formal and informal settings.

Formal Supports

Each participant provided examples of formal supports and their experiences with implementation of those same supports. There were two distinct subthemes that emerged from the data: positives to formal supports and challenges to formal support. Three of the five participants described formal supports as *“supports that are put in place by the system”* or *“people that get paid to be supports.”* Participants listed these supports as: *“child protection, CTSS (children’s therapeutic support systems), ARMHS (Adult Rehabilitative Mental Health Services), therapies such as: in-home therapies, in-office therapies, or pre-school day treatment, and IEP’s (Individualized Education Programs) with the school district.”*

One participant described formal supports as the guidelines one follows to become a foster parent. That participant shared *“the things that are required to be a foster parent: the set of rules, background checks, and providing therapeutic supports.”* Foster parents are responsible to fulfill certain requirements for foster children including: doctor, dentist, educational services,

and therapeutic services. This same participant felt that those requirements are considered formal supports.

Participants shared that formal therapeutic supports begin with the individual completing a diagnostic assessment. One participant shared that there are many services that can be recommended by the diagnostic assessment. *“As a therapist I might recommend individual therapy, theraplay, in-home skills, occupational therapy, or medication management. I would classify all of these services as formal supports.”* Participants described the treatment planning process as *“long term and short term objectives.”* Treatment plans are created, reviewed after each session, and updated every 90 days. Treatment plans are one tool that is used to measure progress and provide a timeline for the length of recommended therapeutic services. One participant stated:

“The length of treatment can vary, typically we say at the shortest 90 days through one treatment plan, but it varies on the client. We know when to end services when goals are met. It is a collaboration with the therapist, skills worker, outside agencies, and the caregivers to see if there have been progress.”

Positives to formal supports. Participants spoke of what positive formal supports offer to foster children with attachment disorders. Many participants shared that formal supports can assist in teaching children how to work through their trauma. One participant talked about particular coping skills, *“Things as simple as deep breathing. We know that if you do 12 deep breaths that can physically change the state you are in.”* Along with breathing techniques, participants used emotion regulation and mindfulness.

“Often people with attachment issues or trauma, what their brain does is think about the past and feel depressed or think about the future and feel anxious, so when you come to

mindfulness you come into the present moment and then you tend to feel content and calm.”

All of these formal supports offer an understanding and opportunity to build individual skills. All of the participants spoke of formal supports being led by the client. Formal supports are client-driven and intend to give power to the client receiving services. *“You go based on what the client does, if a kid says we are going to play with the dollhouse, than we are playing with the dollhouse.”* That same participant shared that, *“I go based on what the kid wants to do, I don’t force a kid to do anything because it ruins that relationship.”*

Many of the participants also reflected on the fact that formal supports are measurable. Children are able to utilize these supports and providers are able to track how things are progressing. A participant stated, *“If treatment plan goals have been mastered, there are not any current concerns, and they are starting to generalize those skills, the supports have been successful.”* As well as being measureable, formal supports are also adaptable. *“We do have clients that have had therapy and skills for a while and then other services are referred.”*

While all the participants described different positives to formal supports, they also made mention of challenges that formal supports carry and the difficulty that can be present for clients.

Challenges to formal supports. Depending on one’s service location formal supports can come in abundance or become difficult to find. Participants described the numerous formal supports that are available to children, but one participant described the challenges faced to access and understanding those services. *“If we could have a better understanding of how to access these supports, because I know there are all these services out there and I don’t always know how to access them.”* This participant also shared that there are limitations to receiving these services, *“Sometimes the hard part of formal supports is they are really great if you have*

them, if we can't find them then they are not super helpful, they are just a formal supports you know exist but they are 'imaginary'." This participant felt that there were services that could help meet their needs, but sometimes policies, funding, or lack of service providers makes accessing those services impossible, therefore imaginary.

Participants felt that when they received a referral for services and the child was in foster care, there was missing information about the child's background. Four participants specifically addressed the importance in getting background information from the child protective services worker before developing treatment plans. A participant explained that, *"life events like a custody change or another traumatic event are likely to increase behaviors."* These are facts that therapists need to know. One participant notes that therapists need to remember to not jump ahead and really work to understand where a child is in their neurosequential model, specifically from an attachment lens. *"I think as therapists we just want to jump to, lets process this and make this work, but really developmentally they (children) are probably not at that point."*

Lastly, one participant made an important link between children with attachment disorders and the need to consider conditions such as fetal alcohol syndrome disorders when completing assessments. Although only one participant discussed other disorders, a strong point was made about the importance of having an open mind when working with children. That participant stated, *"FAS (fetal alcohol syndrome) is really big as therapists we sometimes are just working on anxiety and depression, and we aren't taking into account this major piece that could be a part of the puzzle."*

Informal Support

All five participants described informal supports in a similar way. Participants listed *"community supports, church, school, sports, youth group, people in the foster parents life, or*

online supports.” Participants felt that informal supports are communities of people “*who come together with a group of people to work on a specific need without a treatment plan or diagnosis.*” As one participant explained informal supports can be how an adult performs as a foster parent.

When children are placed into care they are continually learning and observing their surroundings. This participant felt it was important for the foster parents to provide a home where “*you use kind words not judgmental words, because those will only continue judgment and fear.*” You need to demonstrate relationships that are healthy “*model healthy relationships with your family, friends, and animal friends, demonstrating what healthy affection is, what a hug is, and that it is safe.*”

Positives to informal supports. Most participants agreed that the positives to healthy supports are that they are not determined by a treatment plan. Informal supports are not linked to a diagnostic assessment or medical insurance. Informal supports are there when all the services providers getting paid to assist a child are no longer involved. Participants explained that informal supports could assist foster parents who are struggling with burnout. “*Being able to say who else or how do we help you access your family.*” One participant spoke of their personal life and the need for informal supports, “*I think that outside supports are such an important part*” and “*As an adoptive parent, I know it is a challenge and I know how much my parents and in-laws supported what we were going through.*”

Challenges to informal supports. Three participants explained the challenges that informal supports have on children and foster providers. The participants felt that providers were more unaware of the informal supports available to them compared to formal supports. One

participant stated, *“I don’t see them implemented; I think it is because people don’t know where they can get them (informal supports) or what type of support they can get.”*

Two participants felt there were no informal supports for a child’s family supports. *“What I have never found is sibling support or supports for biological parents who are working with the system, for them to miss work or transportation.”* Another participant felt that children don’t have a lot of follow through with informal supports: *“they don’t have a car so they can’t get to church or friends’ houses; their opportunities are a lot less.”* Participants felt that there was more of an emphasis on formal supports. Informal supports were not implemented or assured of completion. One participant shared, *“Whereas formal supports are medically necessary, we can get a medical ride to get them there,”* however, those same rides do not cover transportation to sporting events, clubs, or religious meetings.

Involvement of biological and foster parents

There was an overwhelming consistency in the participants’ engagement with the biological parents of the foster child. All five participants stated that there is often a severe lack of involvement from the biological parent. One participant stated, *“It is not often that I get the biological parents who are a part of the system”* another stated, *“I usually see phone calls from the biological parents, there is not really a lot of follow through on anyone’s part, I wish I had more involvement with them.”* One participant stated, *“I do not have a whole lot of contact with them (biological parents). Children may be functioning fine with the foster parents, but I don’t know how they function with the biological parents, and that is a problem.”* Finally, one participant discussed the difference when children are placed in relative foster homes compared to non-relative foster homes. The participant stated that, *“There is a disconnect because the relative is conducting more of that contact, kids have more contact with the biological parents*

when placed with relatives, but the therapist contact with the biological parents is about the same, which is not much.

Likewise, the participants stated there is still a lack of communication with the foster parents and the service provider, but it is enhanced compared to the engagement of the biological parents. One participant shared that, *“There is more involvement from the foster family in-home and in-office. It is more collaboration on how the family is functioning.”* Another participant mentioned that the age and needs of the child would depend on if the foster parents were brought into a session. *“With older kids I don’t typically bring the foster parent in unless there are a lot of behaviors. If it is a younger kid I am helping the foster parent to have some psychoeducation or attachment based stuff.”* One participant discussed the limitations to having contact with foster parents, *“In my experience I barely had any foster parents that wanted to talk to me or were not allowed to talk to me because they didn’t have a release.”*

Differences in Service to Foster Children

When the participants were asked about differences in service delivery, many singular approaches were presented. One participant spoke directly about the number of adjustments foster children face: *“transitions from mom, to grandma, to aunt, then to foster care, extra stressors”* compared to children who have not been involved in the system. Although this participant highlights an increase in transitions, the participant stated, *“my therapeutic approach doesn’t change with each child, (if the child is in foster care) it will prompt me to say I need more information.”* The provider went on to explain that their overall therapeutic process doesn’t change from child to child, but if the provider is aware the child is in foster care, it prompts getting information from the child protection worker.

Another participant made no reference to a change in service delivery, but made mention of foster children having more people and services involved. This participant stated, *“There is more coordination of care, which is a good thing. They (foster children) often have case managers who are able to help connect all the people.”*

One participant described attachment and a lack of narrative as large differences between children in foster care and those who are not. This participant stated, *“There is that attachment piece, the hope is most children grow up with secure healthy attachment, kids placed or adopted can have disrupted attachment, so I work on helping them form healthy attachments.”* This participant stressed the importance of helping children form narratives.

“Kids who have been living with the same family have a good sense of who they are, where I notice kids who have been in foster care have timelines that don’t line up. There needs to be an understanding of who I am and when two people who are supposed to tell you can’t, then there is difficulty in self identity.”

Only one participant debated the influence of culture when working with foster children referring to diagnosing. This participant spoke directly about the cultural impacts and diagnosing reactive attachment disorder. *“I think there is a major cultural component in rearing children. I am just thinking about this cultural consideration that I think the DSM-5 missed, they just go to what the current western culture believes is right.”* This participant also spoke of the importance of understanding individuals with complex trauma as a culture. *“In therapy we try to unlearn and reteach how to understand things again and rebuild that meter that tells us something is wrong.”* The idea that the culture of the family may be negative, but it is that child’s normal. *“If children continue to see their parent raped or beat, then they enter relationships similar to that because it is normal, it is not a sense of giving up, they just don’t have those alarms going off.”*

A Better World

All five participants felt that the system provided to children in foster care could be improved. Three participants felt that communication between all providers needs to improve. Communication can lack between different entities including the therapist, case managers, biological parents, and foster families, which can decrease the continuity of care for the child. One participant stated, *“When there is more communication with all the providers, then you have 24-hour carry through and generalization; that won’t happen if they are not involved.”* Another participant described the system as *“our own little silos and once and while we shoot something over or make a phone call. There just needs to be more communication.”*

Two participants spoke of the importance of training and a need to increase education for all service providers. *“Foster providers need trauma-informed classes”*, one participant stated. Another participant stated, *“Judges, probation officers, and anyone that is going to work in the system needs training, they need master’s level classes in development and training.”* One participant went further to discuss the need for anecdotal data to be shared. This participant stated, *“We need to be taking the time to publish, to educate others, and that needs to be valued.”* Lastly, one participant described a magical place. *“This agency would have a whole team of people who are experienced in this attachment lens and that would overlap with social services, therapy, and occupational therapy.”*

Each participant identified numerous strengths for children in foster care whether they are provided as a formal support or informal support. Children in foster care have many supports available to themselves, their parents, and their foster parents. Participants also highlighted many areas for growth as we provide care to this specific group of children.

Discussion

The purpose of this study was to better understand the different types of supports available to children, parents, and foster parents who are within the child protection system. It was also important to explore the strengths and limitations in accessing those different types of services. This study provided many similarities between previously published literature and the outcomes from this research study, specifically when considering formal supports, informal supports, and an overall understanding of trauma-informed care.

All of the participants interviewed provided a strong understanding of implementation of a trauma-informed mindset when working with individuals who have been in the foster care system. Participants shared a similar belief that when one sees the world through a trauma-informed lens they are able to accept that an individual's behaviors and responses are normal for their lived experiences. Many participants expressed a need for education. Education within the family system to help families better understand the impacts of trauma, is also a way to carry out a trauma-informed perspective. Education about trauma is provided over many sessions and can utilize visual tools to help individuals conceptualize the effect trauma has on a person. An example of a visual tool may be the adverse childhood experiences (ACE's) questionnaire. The ACE's is able to score the amount of childhood experiences and assist in painting a picture of how those occurrences may impact a child's life as they move into adulthood.

There was an overall consensus among the participants that when referring to formal supports for children in foster care, we are discussing individuals or aids that are put in place by the system and who are paid to provide a particular service. Formal supports could be different types of therapies, child protection system, school services, or a set of rules and regulations that are mandatory to follow by the foster provider.

There were many positives to having these types of supports. Therapies can assist a child to work through past trauma and teach calming techniques, which can help children to do better in school or at home. Formal supports can also offer education to family members providing care for children with attachment disorders, whether the family member is brought into the therapy session or through education as a skill based service. One strong difference participant's noticed between formal and informal supports, is that formal supports are measurable. Treatment goals are measurable in a therapeutic setting, as well as child protection workers where case plans are created with goals, which can also be measured.

As there were many positives to formal supports identified by this sample, there were also limitations, which the participants noted. Service location, waiting lists, and lack of providers can be a limitation to formal supports. Even when services are in a location that is accessible to the child, they may be difficult to navigate. Different formal supports have specific referral processes that must be completed prior to beginning a service. When getting a referral is challenging or needs a specific approval, this can delay access to needed services.

Participants noted that when working with children in foster care with attachment disorders, it could be difficult to remember to stop and get more information from the child protection worker. A few participants also noted the importance of slowing down and really looking at where the child is developmentally and if they are in a place to address past trauma.

All the participants described informal supports in a similar manner. These included supports such as communities, church, sports, youth groups, or individuals in the families' lives that offer assistance. Overall, informal supports are not characterized by treatment plans and can continue to be available after goals have been achieved. Participants agreed that informal supports are just as helpful to the child and family as formal support. Participants noted that

similar to formal, informal supports also have limitations. Participants noted that they felt families were often less aware of the informal supports in their communities compared to the education they receive about formal supports. Participants perceived that informal supports were also implemented less due to concerns for funding, whether that is funding to cover sports enrollment or providing transportation to youth group.

Participants shared overwhelming similarities when discussing the engagement of both biological and foster parents in a child's services. Many participants noted that never making in person contact with the biological parents was a consistent occurrence. Participants agreed that they wanted to have more involvement from the biological parents, but described limited follow through with implementation. Participants again agreed that there is a significant gap in contact between the child's foster providers and the service providers. In some cases when services are provided in the home there is more engagement of the foster providers, but this still continues to be a need.

Participants discussed overall differences in services delivered when comparing children in foster care to children never being placed in care. Participants stated that typically children in foster care have experienced many changes in their lives. Many participants stated that their overall approach to therapeutic service delivery does not necessarily change; they did mention that there could be large differences in the children themselves. Children in foster care typically have many different providers involved that all need to coordinate together. Participants also discussed the life experiences of a child in foster care, as some children have a difficult sense of self and struggle with understanding their own narrative.

Lastly, participants reflected and shared their views about what a better system could look like for children in foster care who struggle with attachment disorders. Many providers

highlighted the same needs as: increased communication between all parties, more education to service providers, and a continued need to share our understandings and make that information known.

Implications for Clinical Practice

There are many suggested practice implications that are emphasized by these findings. For any service providers who engage with a child in foster care, it is important to educate yourself about the child's position in the child protection matter. This could include: education about that specific reasons the child has been placed outside of the home, the difficulties that biological parents are facing, and tracking the child's adjustments in care. This research suggests that providers should use a trauma-informed lens when working with foster children. This means the provider is open to meeting the child where they are in "their journey" and work to connect with individuals in that child's world. It is important to emphasize the communication with the child's team, and encourage the involvement of family and other service providers.

Implications for Research and Policy

This study's findings suggest potential research opportunities including a need to look further into working with children in foster care who have dual diagnoses, specifically the impacts of fetal alcohol syndrome disorder. Children in foster care have complex historical narratives and understanding complex trauma and dual diagnosis for these children will be important to provide the best care. Practitioners can build on existing models to assist in understanding a child and families narratives. Family group decision making meetings (FGDM) are a way to bring all the important individuals to one table to review the strengths and needs of a family, while assisting a problem solving within the families current supports. Practitioners have recently been limited to extended coordination of care due to insurance billing guidelines,

but with recent changes, therapists are able to bill insurance under clinical care consultation (CTSS). There could also be extended research opportunities to examine the different types of therapeutic supports, which populations they work best for, and optimal ways of implementation. This could be extended further to gain insight into therapeutic processes in other states and countries.

As the research showed there were strong limitations to accessing both formal supports and informal supports. Policy makers need to take a deeper look at how children can access formal supports, decreasing waiting lists, and increased emphasis on expanding services to rural communities. Informal supports also need to be considered as an important component to a child's well being. Policy makers need to consider working with insurance companies to provide transportation to children accessing positive community supports. Those same policies could provide additional funding for schools to lower or waive sport and club fees so children could build healthy connections within their community.

Strengths and Limitations

The strengths of this study are that the results positively correlate with the findings from the literature. This study also opens the communication about trauma-informed services for children in foster care, as current research is limited. The limitations of this study are that the sample size is small, meaning that the information gained cannot be generalized to a larger population. Another limitation is that the professional's interviewed were from a rural area in Minnesota. The geographic area may change the sample results as individuals from suburban areas or outside Minnesota were not explored.

Future Research

With any study, there can be questions that have gone unanswered. After analyzing the data, suggested future research could consider taking a deeper look into specific services available to children who have a history of foster placement. With there being multiple therapeutic interventions, it would be interesting to explore what services tend to be more successful. Research could also examine the impacts of trauma on a child before entering placement and then once in placement, looking at how to decrease the trauma that is increased by being placed in foster care.

The involvement of biological parents and foster parents in a child's services turned out to be a challenge for most providers. Taking a look at why participation with both biological and foster parents within a child's service is so small would be a strong recommendation for future research. This research study could also be conducted with questions directly to foster children, requesting their personal experiences accessing services, what they feel they need, and what the limitation may be.

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Appendix A: Informed Consent Form

**Consent Form
[1153052-1]****Trauma-Informed Care For Youth In Foster Care**

You are invited to participate in a research study about children in foster care. You were selected as a possible participant because you are a social worker with current or previous therapeutic work with children in foster care with an attachment disorder. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Jordyn Hubin, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. David Roseborough. The Institutional Review Board at the University of St. Thomas approved this study.

Background Information

The purpose of this study is to understand the formal and informal supports available to foster families of children with attachment disorders who reside in foster care.

Procedures

If you agree to participate in this study, I will ask you to do the following things: participate in a semi-structured interview of 45-75 minutes, allow me to audio tape the interview, and allow presentation of data gathered to peers in Social Work Practice Research course.

Risks and Benefits of Being in the Study

This study has a risk of coercion. Coercion will be minimized by the researcher contacting potential interviewees via telephone to explain the purpose of the study, the researcher will not ask potential interviewees to agree to participate via phone, instead the researcher will invite potential interviewees to inquire for more information if interested in becoming a research participant. Once individuals inquire, a detailed email will outline the role of the interviewee and provide the consent form and interview questions for review.

The study has no direct benefits.

Privacy

Your privacy will be protected while you participate in this study. As the interviewee you will be able to choose a neutral location and time of the interview.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include audio recordings and written transcriptions. The interviews will be audio recorded, uploaded to a locked computer, and deleted off the recorder within 24 hours. All recordings, transcriptions, and consent forms will be saved on a double locked computer. All transcriptions will be deleted by May 31st 2017. All transcripts will omit any identifying information. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. You may skip any questions you do not want to answer and may stop the interview at any time. You can withdraw by telling the interviewer you wish to end the interview. As the interviewee, you can decide if you want the interviewer to use any data already completed. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled.

Contacts and Questions

My name is Jordyn Hubin. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 715-456-3299 or hubi2618@stthomas.edu. You can also contact research advisor David Roseborough at 651-962-5804 or djroseboroug@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B: Interview Questions

Research Question: What is one professional's view on treatment approaches for children diagnosed with attachment disorder?

1. Tell me about yourself including: job title, educational background (if relevant) and length of time working with children with attachment-related disorders?
2. What has been your experience working with children in foster care?
3. What has been your experience working with children diagnosed with attachment related disorders in your current setting?
4. How do you define trauma-informed care?
5. Have you or how do you use trauma-informed care in your work with children with attachment disorders?
 - a. How do you encompass trauma-informed care with foster parents and foster children?

Formal

6. How do you define formal supports for children in foster care with attachment disorders?
7. How are formal supports implemented for children with attachment disorders in your setting?
 - a. How are formal supports implemented for children with attachment disorders specifically children in foster care?
 - b. What specifically do therapeutic programs address?
 - c. What is the length of those therapeutic services?
 - d. How do you know when to end a therapeutic service?

8. What is the involvement of the foster family when providing what you described as formal supports?
 - a. Involvement of biological parents?

Informal

9. How do you define informal supports for children in foster care with attachment disorders? Can you offer some examples?
10. How are informal supports implemented for children with attachment disorders in your setting?
 - a. How are informal supports implemented for children with attachment disorders, specifically children in foster care?
11. What is the involvement of the foster family when providing what you described as informal supports?
 - a. Involvement of biological parents?
12. What are the differences, if any, in providing therapeutic services to children in foster care from children who have not resided in foster care?
13. What could a better system look like?
14. Anything else you would like to share about your experience working with children diagnosed with attachment disorders?

Thank you.